EPI TESTIMONY

Testimony Given By

Elise Gould, Ph.D.
Director of Health Policy Research
Economic Policy Institute

In a hearing before the
U.S. House of Representatives Committee on Ways and Means

"Health Reform in the 21st Century: Employer Sponsored Insurance"

Wednesday, April 29, 2009

Longworth House Office Building, Room 1100

Good Morning Chairman Rangel, Ranking Member Camp, and distinguished members of the Ways and Mean Committee. My name is Elise Gould, and I am a health economist and director of health policy research at the Economic Policy Institute. I appreciate the opportunity to appear before you today to share my views.

Employer-sponsored insurance (I will call it ESI from here on out) provides insurance for the majority of under-65 Americans. ESI, particularly among large firms, works because it pools risk, has low administrative costs, and offers a stable source of coverage for a large share of the population. Many of these people enjoy the benefits they receive and would like to keep them. However, we have seen a weakening in ESI over the last several years and it is important to examine strategies – and I commend Chairman Rangel in holding a hearing to examine strategies – to strengthen ESI and find ways to provide this high-value coverage to more Americans.

The rise of employer-sponsored health insurance

The employer-sponsored health insurance industry in the United States did not flourish until the middle of the 20th century, although there were numerous early attempts to protect against the costs of medical care. During World War II, employers offered health benefits as a way to attract workers when the National War Labor Board froze wages.

In 1954, Congress amended the Internal Revenue Code to clarify and expand a 1943 administrative tax ruling that granted tax exempt status to employers' contributions for their employees' group medical and hospitalization premiums. Excluding premium contributions from taxable income made one dollar worth of health insurance less expensive to provide than one dollar worth of wages. In general, the tax exemption – effectively a government subsidy – reduced after-tax insurance premiums enough to encourage even the healthiest employees to enroll. In this way, sustainable risk pools were formed and group policies became more attractive to insurance companies.

Over the latter half of the 20th century, employer-sponsored health insurance became increasingly popular. Workers have grown to rely on employers to provide health insurance, and employers have used it as a tool to attract and retain the best workers and improve the health of their workforce.

The current state of employer-sponsored insurance

Employment-based coverage remains the most prominent form of health insurance in the United States. About 63% of the under-65 population has insurance either through their own or a family member's employer (Gould 2008). Let me take a moment to characterize the population which has access to this valuable insurance source (**Table 1**).

Americans, ages 25-64, are more likely to have employment-based insurance than children and young adults. White, non-Hispanics have coverage rates 20-30 percentage points higher than their non-white counterparts. Over 80% of the college-educated and 80% of those in the top half of the income distribution have ESI coverage. In fact, if you break the non-elderly population into fifths by household income, we would see that those in the top income fifth are nearly four times more likely to have coverage than those in the bottom fifth.

Not surprisingly, workers are more likely to have ESI than the non-working population. Over 70% of all workers and nearly 75% of full-time workers have ESI. As

with the general population, however, highly educated workers have high rates of coverage, as do those at the high end of the wage distribution.

If we look for a moment at only those with a strong labor force attachment, that is, private sector workers who get insurance through their own job, we find that white collar occupations have higher rates of coverage than blue collar workers and far higher rates than service sector occupations (**Table 2**). Workers in manufacturing, mining, and information industries have higher rates of coverage than those in other industries. Workers in large firms have much better access to coverage than workers in small firms. In a minute, I will explore in more depth the unique difficulties small businesses face in the current health insurance marketplace.

So, we see that the employer-sponsored health insurance system is working well for tens of millions of American workers and their families. We should ensure that they retain this high-quality coverage. That said, the problem remains that many folks are left out of or are ill-served by the employer-sponsored system. Given the pitfalls of the individual insurance market (which you heard about at last week's hearing), this leaves far too many Americans exposed to both health and financial risks.

To better understand the weaknesses in the system today, I want to explain what has been happening with ESI over the last several years.

Recent trends in employer-sponsored insurance

While ESI remained the dominant form of health coverage through the 2000s, the share of people covered by it declined every year since 2000. This erosion, or unraveling, has been occurring even during the economic recovery. During an expansionary period, we would have expected coverage to increase as employment grew, but it simply did not. High and rising health costs are mostly to blame. Average premiums for an employer-sponsored family plan have risen nearly 120% since 1999, three and a half times faster than workers' earnings and more than four times faster than inflation (KFF/HRET 2008).

As a consequence, the percent of people with ESI has fallen over 5 percentage points since 2000. In other words, over 3 million fewer people under the age of 65 had employment-based insurance in 2007 than in 2000. Taking into account population growth, it is fair to say that as many as 14 million more people under 65 would have had employer-sponsored health insurance in 2007 if the coverage rate had remained at the 2000 level.

Where there are disparities in coverage, they have only been exacerbated in the last several years. While no group has been immune to the declines in coverage, some are hit harder than others.

Those at the middle and bottom of the income distribution – already shut out from the employer system in large numbers – experienced losses much greater than those at the top. Children experienced some of the largest declines in employer-sponsored health insurance, a drop from 66% covered in 2000 to less than 60% in 2007. We know it is only the strength of public health insurance programs that has prevented even more children from becoming uninsured as ESI fell.

While some workers fared better than others in the most recent year of data, no category of worker has escaped the declines since 2000. Even full-time workers, workers with a college degree, and workers in the highest wage quintile experienced declines in coverage over the 2000s.

Small businesses struggle to cover their workers

So far, I have documented an unevenness of coverage by race, income, employment status, and firm characteristics. I want to take a minute to talk about one group of firms that have the hardest time providing insurance to their workers. These are small businesses. And, as we consider solutions to strengthen insurance coverage across the United States, we really need to pay attention to small business owners and their workforce.

The coverage rate in firms with fewer than 10 workers is less than half that of workers in firms with more than 100 workers (**Table 2**). No matter how you define it, workers in small firms are much less likely to have ESI coverage as those in large firms.

Small businesses offer insurance to their employees at much lower rates than larger firms (**Table 3**). Only 43% of workers in small firms (less than 10 workers) are in firms that offer health insurance, compared to over 95% in large firms (more than 100 workers) and 87% in all firms across the economy. While most workers who are offered ESI take it up, it is not surprising, given the lower offer rate, that a far smaller share of workers in small firms are eligible and actually enrolled in employer-sponsored health insurance plans.

In fact, half of all the uninsured are employed by a business with fewer than 100 workers, and 36% work in firms with fewer than 25 employees. That said, among offering firms, small firms actually contribute a higher share of the single plan premium than their large firm counterparts as a way to cover a larger share of workers and maintain at least a minimum sized risk pool (MEPS).

Small firms that do offer health insurance face high costs, paying on average 18 percent more than larger firms for identical policies due to higher and more variable health risks, a lack of competition amongst insurers, and greater administrative expenses (KFF/HRET 2008). You heard last week from David Borris, a small business owner in Illinois, who pays 13% of his covered employees' payroll on health insurance (Borris 2009).

I know, in 2007, at the small firm where I work, with less than 30 days notice, our insurer raised rates by 27%, forcing us to switch carriers at the last minute, which is not easy in the limited marketplace. This year, our new insurer increased our rate by 15% to 23%, depending on plan type. It is these high and unpredictable costs that have made it increasingly difficult for small firms to provide the insurance they want to offer their workers.

The future of employer-sponsored health insurance

So, what does the future hold? It is truly bleak unless there is action. The current economic downturn and forecasts of high unemployment indicate continued erosion of employer-sponsored insurance in the near future. I estimate that by the end of 2009, nearly 50 million non-elderly will be uninsured. The link between insurance and work has become a tradition in this country. ESI, particularly in large group markets, can pool risk, lower administrative costs, and maintain stability. But we must recognize its limitations.

As we move forward in what I hope to be ground-breaking steps towards meaningful health reform, we must be wary of quick fixes to our insurance system. One such fix involves taxing health benefits.

Tax exclusion

Some argue that a cap on the tax exclusion for ESI premiums would be a great way to raise money for health reform. They claim that it primarily would affect rich people with expensive plans – dare I say enviably high-quality plans. Research shows that taxing high-priced health coverage will heavily burden two groups – workers in small firms and workers in employer pools with higher health risks, such as those with a high percentage of older workers (Gould and Minicozzi 2009). Capping the exclusion would also disproportionately affect firms in certain industries and certain geographic areas.

Using the small business example, I'm going to take a minute to illustrate how a policy of taxing health benefits would weaken small business owners' ability to offer coverage to their workers.

Capping the tax exclusion exacerbates the problems small firms already have. It would encourage the young and healthy to opt out of these pools, and upon their exit, premiums would likely rise for those remaining.

Small businesses are paying high premiums for the insurance they provide to their employees not because the plans are especially lavish, but because they have high administrative costs and include too few employees to constitute the broader risk pool that would qualify them for lower premiums. Adding a tax on top of the cost of premiums they already pay will likely drive many more into the ranks of the uninsured. This disproportionately affects small business, in part because they face higher costs, but also because they are more sensitive to price increases.

It is worth noting that the high price of these plans may not stem from any bells and whistles in their coverage but rather from a fundamental inequity in the way that insurance for these groups is currently priced. A policy of taxing health benefits over a certain dollar amount is a blunt instrument that may do great harm to the very people we should be striving to help. Furthermore, these problems would only be exacerbated by a cap that fails to keep pace with future health care costs or one that does not take into account the relative costs of single and family plans.

Considering the negative impact capping the tax exclusion would have on insurance coverage, it is important to point out as well that the idea of taking from one group to pay for coverage for another ignores the dynamics of coverage. The insured, or just the population with ESI for that matter, is not a static group. We know that over one-third of the under-65 population is uninsured for some time over a three-year period (Kriss et al. 2008), and over half of those who lose ESI become uninsured (Gould 2009).

Despite all the reasons not to cap or do away with the tax exclusion, it remains true that doing so would free up enormous sums of money to defray the costs of fundamental health reforms. That said, changing the tax treatment should be the dessert not the appetizer, and it should not be considered until large-scale health reform is in place to cover everyone.

Solutions that work

Health reformers must join forces to strengthen ESI while insuring everyone and containing costs. Let us now examine approaches to health reform that can serve to shore up ESI and cover those who have fallen through the cracks.

Universal coverage means fundamental changes in the overall system where ESI sits as a leading member. There has to be a way for the non-workers, part-time workers, and

even those full-time workers who have been closed out of the current system to find affordable coverage.

One essential component of meaningful health reform is improving the health insurance marketplace. Private market reforms – such as community rating and guaranteed issue – can improve competition between insurance companies by ensuring that this competition takes place on the grounds of efficiency and not on companies' ability to sort the population for the lowest health risks. That said, even with regulations to prevent risk selection in place, research has shown that private insurers will still employ a number of strategies to push high-cost enrollees off their rolls, or keep such high-risk individuals from enrolling in the first place (Jost 2009). For example, rigorous utilization reviews and poor service can push high-cost enrollees to find alternative sources of coverage. Given the potential for this behavior, private market reforms would not be enough.

The best way to ensure that coverage is universally made available to those who do not have good ESI is to construct a national insurance exchange that includes a public health insurance option. A benefit of the exchange and the public option is that those employers who are having a hard time providing coverage to their workers can find a viable opportunity in the exchange.

A public health insurance option is an essential part of a new national exchange. While giving Americans more choices for coverage, it also has the added advantage of increasing competition to already limited markets, reducing costs and cost growth, driving quality advancement and innovation, and serving as a benchmark for the insurance market (Hertel-Fernandez 2009).

Let us take these reform options in the context of groups of workers who have been hardest to insure in the employer market. I have already mentioned workers in small businesses. About 70% (Main Street Alliance 2009) of small businesses want to provide insurance to their workers. A national exchange with a public health insurance option strengthens the ability of these employers to make an appropriate contribution for this coverage by slowing the rate of cost growth and reducing insurers' ability to charge discriminatory prices.

Low-wage workers and part-time workers are also groups we need to pay close attention to as we strengthen ESI and reform the health insurance system. While 87% of workers are in firms that offer health insurance, only 53% enroll (**Table 4**). This gap between offered and enrolled is a function of eligibility and affordability.

On the eligibility front, part-time workers are left in the dust. While part-time workers may be employed by a firm that offers insurance to some of its workforce, their part-time hours make them ineligible to participate. In offering firms with a high share of part-time workers, only one-third of workers are eligible, as compared to 85% of workers in firms with a small part-time workforce.

Turning to workers in firms with a low percentage of low-wage workers (earning at or below the 25th percentile for all hourly wages, or $10.50/hour in 2006), the rubber meets the road in the enrollment decision. While the vast majority enroll, only 65% of eligible workers in low-wage firms enroll compared to 82% of eligible workers in high-wage firms. This is evidence that they simply cannot afford the premium.

Health reform efforts must take into account both the difficulties of insuring part-time workers and the necessary subsidies required to insure low-wage workers. In

constructing policy, we need to be careful not to increase inefficiencies in the labor market, such as encouraging employers to switch from a full-time to a part-time workforce, while at the same time providing opportunities for universal coverage. Offering the possibility for low-wage firms to contribute a share of payroll as opposed to a flat premium contribution greatly relieves their burden.

Those concerned with an employer requirement to participate in the health insurance provision of their workers need to look no further than Massachusetts' experiment with providing universal coverage. Mid-2008 data from Massachusetts indicate strong support from firms and an increase in the number of offering firms from 73% to 79%. When asked in a survey, small Massachusetts firms (3 to 50 workers) bucked the national trend by answering that they were not likely to terminate coverage or restrict eligibility (Gabel et al 2008).

Containing health costs and cost growth through a national exchange with a public insurance option – while encouraging shared responsibility across firms and across sectors – may have the added benefit of improving competitiveness. The median contribution to health premiums is 11% of payroll for covered employees (KFF 2008). A full 25% of those firms had employer costs of at least 16.5% of payroll. There is striking unevenness in this burden across firms, particularly by industry (Table 2). Health reform that evens this burden across firms will insure that a businesses' competitiveness will rest on grounds that are amenable to their own actions – like how efficiently they run their business – and not on factors outside of their control – like the current health of their workforce.

Cost-containment is a crucial part of reform because high and rising health costs either crush workers' wages or raise prices for those firms that provide health insurance. Reducing overall costs and sharing the burden of providing coverage across industries would particularly help firms that disproportionately cover their workers already and benefit those firms that are exposed to international competition (manufacturing, most prominently) to remain competitive while also paying decent wages to all workers.

Conclusion

So, when we think of strategies moving forward, we want to consider those that strengthen people's access to affordable, consistent coverage. By building on what works well in today's American health care system – ESI for the bulk of the workforce as well as extremely popular public programs like Medicare – we can move with minimal disruption to universal coverage. Besides providing needed health and financial security, universal coverage is the first step we need to take toward restraining cost growth throughout the system. Failing to rein in costs will lead to falling living standards, lower wages, less competitive employers, and strains on public budgets. While the benefits to slowing health care costs are huge, many difficult decisions will have to be made on the way. Universal coverage assures that everybody will feel like a stakeholder in these decisions and that nobody need fear being left behind.

Thank you and I am more than happy to answer any questions you may have.

Table 1. Employer-sponsored health insurance coverage for non-elderly population and workers

Employer-sponsored health insurance coverage for non-elderly (under 65) population

	2000	2007	*2000-2007*
Under 65 Population	68.3%	62.9%	-5.4
Age			
0-17	65.9%	59.5%	-6.5
18-24	53.5%	48.4%	-5.1
25-54	72.9%	66.8%	-6.1
55-64	68.1%	67.8%	-0.3
Race			
White, non-Hisp.	75.6%	70.8%	-4.8
Black	56.1%	51.6%	-4.5
Hispanic	45.8%	41.4%	-4.4
Other	64.3%	61.7%	-2.6
Nativity			
Native	70.4%	65.1%	-5.3
Foreign Born	52.2%	47.4%	-4.8
Education*			
Less than H.S.	39.0%	30.1%	-8.9
High school	65.6%	56.4%	-9.2
Some College	73.3%	67.0%	-6.3
College	83.5%	80.0%	-3.6
Post-College	87.6%	85.8%	-1.9
Household income fifth			
Lowest	28.7%	21.9%	-6.8
Second	61.7%	53.6%	-8.1
Middle	77.4%	71.6%	-5.7
Fourth	85.6%	81.9%	-3.7
Highest	88.4%	86.4%	-1.9

Employer-sponsored health insurance coverage among workers

	2000	2007	*2000-2007*
All workers	74.8%	71.0%	-3.7
Race			
White, non-Hisp.	79.6%	76.4%	-3.2
Black	68.3%	65.6%	-2.7
Hispanic	53.4%	50.0%	-3.4
Other	70.6%	69.5%	-1.0
Nativity			
Native	77.4%	74.1%	-3.2
Foreign Born	58.7%	54.0%	-4.7
Education			
High school	71.8%	65.5%	-6.306
	85.3%	82.7%	-2.61
Wage quintiles			
Lowest	49.4%	44.9%	-4.431
Second	69.0%	62.5%	-6.444
Middle	80.7%	77.8%	-2.9
Fourth	86.9%	85.0%	-1.9
Highest	88.6%	85.9%	-2.6
Work time			
Full Time	77.6%	74.3%	-3.277
Part Time	60.4%	54.6%	-5.852

* Education reflects own education for individuals 18 and over and reflects family head's education for children under 18.
Source: Author's analysis of the March Current Population Survey, 2001-08.

Table 2: Employer-sponsored health insurance coverage for private sector workers*

	2000	2007	*2000-2007*
All workers	58.9%	55.4%	-3.4
Occupations			
White collar	65.0%	61.9%	-3.0
Blue collar	59.0%	53.9%	-5.0
Service	33.9%	29.5%	-4.4
Other	26.7%	22.2%	-4.5
Firm Size			
9 or fewer	30.6%	27.1%	-3.5
10 to 24	42.9%	38.4%	-4.5
25 to 99	56.0%	52.7%	-3.3
100 to 499	65.9%	63.1%	-2.8
500 to 999	67.1%	64.9%	-2.2
1000 or more	69.9%	67.5%	-2.4
Industry**	**2002**	**2007**	***2002-2007***
Agriculture, forestry, fishing, hunting	37.1%	27.1%	-10.0
Arts, entertainment, recreation, and accomodation	32.5%	31.9%	-0.6
Construction	47.5%	44.1%	-3.4
Education, health, and social services	59.4%	60.2%	0.7
Finance, insurance, and real estate and leasing	65.8%	65.1%	-0.7
Information	73.0%	72.7%	-0.3
Manufacturing	72.7%	70.2%	-2.5
Mining	78.4%	73.9%	-4.5
Other services (except public administration)	40.1%	37.4%	-2.7
Professional, scientific, management, administration	57.4%	56.0%	-1.4
Transportation and communication	66.9%	63.0%	-3.9
Wholesale trade	53.9%	51.6%	-2.2

* Private-sector, wage and salary workers, age 18-64, who worked at least 20 hours per week and 26 weeks per year.
** Industry classifications changes make it impossible to compare 2006 with years earlier than 2002.
Source: Author's analysis of the March Current Population Survey, 2001-08.

Table 3: Offer, eligibility, and enrollment, by firm size, 2006

	All firms	Less than 10 employees	10-24 employees	25-99 employees	100-999 employees	1000 or more employees
Percent of employees in offering firms	86.9%	43.3%	67.4%	85.0%	95.1%	98.7%
Percent of employees eligible	67.3%	35.5%	51.4%	62.7%	73.4%	77.2%
Percent of employees enrolled	52.7%	28.8%	39.4%	47.5%	56.6%	61.3%

SOURCE: 2006 Medical Expenditures Panel Survey, Insurance Component (MEPS-IC)

Table 4. Percent of private-sector employees offered, eligible, and enrolled in ESI, 2006

Characteristics	Offered	Eligible	Enrolled
United States	86.9%	67.3%	52.7%
Percent low wage employees			
50% or more low wage	75.5%	45.5%	29.4%
Less than 50% low wage	91.4%	76.0%	62.0%
Percent full-time employees			
Less than 25%	56.1%	20.5%	9.4%
25-49 %	80.7%	37.2%	23.4%
50-74 %	81.9%	53.2%	37.7%
75% or more	91.6%	77.8%	62.9%

SOURCE: 2006 Medical Expenditure Panel Survey, Insurance Component.

Sources

Borris, David. 2009. "Challenges in the Small Group Health Insurance Market: A View from Small Business." Testimony before the Committee on Ways and Means, U.S. House of Representatives. April 22.

Gabel, J.R., H. Whitmore, J. Pickreign, W. Sellheim, KC Shova, and V. Bassett. 2008. "After The Mandates: Massachusetts Employers Continue To Support Health Reform As More Firms Offer Coverage." *Health Affairs* 27(6):566-575.

Gould, Elise. 2008. "The Erosion of Employer-Sponsored Health Insurance." EPI Briefing Paper #223. Washington, D.C.: Economic Policy Institute.

Gould, Elise. 2009. "Insurance Instability: a story of churning in America." Unpublished Working Paper.

Gould, Elise and Alexandra Minicozzi. 2009. "Who loses if we limit the tax exclusion for health insurance?" *Tax Notes*, Vol. 122, No. 10, pp. 1259-62.

Hertel-Fernandez, Alexander. 2009. "Why a Public Insurance Plan Is Essential for Health Reform." EPI Policy Memorandum #141. Washington, D.C.: Economic Policy Institute.

Jost, Timothy. 2009. "Risk Selection by Private Health Insurers: Why Regulation Cannot Solve the Problem." Unpublished Working Paper.

Kaiser Family Foundation and Health Research and Educational Trust. 2008. "Employer Health Benefits 2008 Annual Survey." Washington, D.C.

Kaiser Family Foundation. 2008. "Employer Health Insurance Costs and Worker Compensation." Washington, D.C.

Kriss, J. L., S. R. Collins, B. Mahato, E. Gould, and C. Schoen. 2008. "Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update." The Commonwealth Fund.

The Main Street Alliance. "Taking the Pulse of Main Street: Small Business, Health Insurance, and Priorities for Reform." January 2009.

Medical Expenditure Panel Survey-Insurance Component. Agency for Healthcare Research and Quality.